

Choices for Care

Flexible Choices Budget Form

Participant information

Participant Goals for Flexible Choices

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|----|-----------------------------------|
| 1) | Name: |
| 2) | Name of surrogate (if applicable) |
| 3) | Medicaid Number |
| | ICD Code: |
| | Date of Birth: |
| | Address: |

Budget Detail

Two-week allowance: \$_____

Budget Item		Bi-Weekly Cost
<i>Administrative fees</i>		
Fiscal ISO		\$18.68
Consultant		\$81.73
<i>Total Administrative Fees</i>		\$100.41
<i>Goods (list)</i>		
<i>Total Goods \$</i>		\$0.00
<i>Adult Day Services</i>	Hours Per 2 Weeks	Rate
Adult Day Hours		\$12.00
<i>Total Adult Day</i>		\$0.00
<i>Services (list)</i>		
<i>Total Services</i>		\$0.00
<i>Cash</i>		
<i>Total cash</i>		\$0.00
<i>Personal Care</i>	Hours/2 wks Hourly wage Taxes etc @16.1%	Worker Total
<i>Total Personnel Costs</i>		\$0.00

<i>Specified Savings</i>	Item Cost	PP to save	Two-week savings
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	<i>Total savings</i>		\$0.00
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Rainy Day Savings			\$0.00
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TOTAL BUDGET: \$_____

Signatures

Effective Date:_____ Next Review Date:_____

Consumer/Surrogate Date

Consultant Date

Note: All dollar amounts are based on two-week periods.